SERFF Tracking Number:	*STFH-126337913*	*State:*	*Arkansas*
Filing Company:	*State Farm Mutual Automobile Insurance Company*	*State Tracking Number:*	*43748*
Company Tracking Number:	*97037 HAR, 97038 HAR, 97039 HAR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.003 Plan C 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*2010 Med Supp/97037 HAR, 97038 HAR, 97039 HAR*		

Filing at a Glance

Company: State Farm Mutual Automobile Insurance Company

Product Name: Medicare Supplement	SERFF Tr Num: STFH-126337913	State: Arkansas
TOI: MS08I Individual Medicare Supplement - Standard Plans 2010	SERFF Status: Closed-Approved-Closed	State Tr Num: 43748
Sub-TOI: MS08I.003 Plan C 2010	Co Tr Num: 97037 HAR, 97038 HAR, 97039 HAR	State Status: Under Review
Filing Type: Form/Rate		Reviewer(s): Stephanie Fowler
	Authors: Barb Metz, Sandy Barnes	Disposition Date: 12/16/2009
	Date Submitted: 10/09/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name: 2010 Med Supp
Project Number: 97037 HAR, 97038 HAR, 97039 HAR
Requested Filing Mode:
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 12/16/2009

Deemer Date:
Submitted By: Sandy Barnes
Filing Description:
October 9, 2009

Jay Bradford, Commissioner
Arkansas Insurance Department
1200 W 3rd Street
Little Rock, AR 72201-1904

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 11/09/2009
Created By: Sandy Barnes
Corresponding Filing Tracking Number:

SERFF Tracking Number:	*STFH-126337913*	*State:*	*Arkansas*
Filing Company:	*State Farm Mutual Automobile Insurance Company*	*State Tracking Number:*	*43748*
Company Tracking Number:	*97037 HAR, 97038 HAR, 97039 HAR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.003 Plan C 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*2010 Med Supp/97037 HAR, 97038 HAR, 97039 HAR*		

Re: NAIC # 176-25178
Individual Accident & Health
2010 Medicare Supplement Policy – Plan A Form 97037 HAR
2010 Medicare Supplement Policy – Plan C Form 97038 HAR
2010 Medicare Supplement Policy – Plan F Form 97039 HAR
Medicare Supplement Outline of Coverage 1002209
Medicare Supplement Application Form 1002336
Medicare Supplement Replacement Notice 125593.1
Medicare Supplement Rates

Dear Commissioner:

Enclosed for filing on behalf of the State Farm Mutual Automobile Insurance Company of Bloomington, Illinois are the referenced forms. These forms are to be used to satisfy the Benefit Standards for the 2010 Standardized Medicare Supplement Benefit Plans effective June 1, 2010.

2010 Medicare Supplement Policy – Plan A Form 97037 HAR
2010 Medicare Supplement Policy – Plan C Form 97038 HAR
2010 Medicare Supplement Policy – Plan F Form 97039 HAR

2010 Medicare Supplement Policy – Plan A Form 97037 HAR will replace Medicare Supplement Policy – Plan A Form 97037 AR, approved October 9, 1996.
2010 Medicare Supplement Policy – Plan C Form 97038 HAR will replace Medicare Supplement Policy – Plan C Form 97038 AR, approved October 9, 1996.
2010 Medicare Supplement Policy – Plan F Form 97039 HAR will replace Medicare Supplement Policy – Plan F form 97039 AR, approved October 9, 1996.

The 2010 Medicare Supplement Policies have been created to satisfy the Medicare Supplement Requirements for 2010 based on Arkansas Rule 27, Section 9.1.
.
Medicare Supplement Outline of Coverage 1002209

Medicare Supplement Outline of Coverage 1002210 includes the 2009 Medicare Deductible Amounts but will be modified once the 2010 Medicare Deductible Amounts have been determined. We have bracketed both the rates and deductible amounts to reflect the variability

that may occur from year to year.

Please note that we have also bracketed the following areas so that required language can be removed as of June 1, 2011:

1. The last sentence in paragraph 1 of the cover page.
2. The second paragraph in the Disclosures section.

A readability certificate has not been completed since the outline being submitted is in the format required by Arkansas Rule 27, Section 17 (D).

Medicare Supplement Application 1002336

Medicare Supplement Application 1002336 will replace Medicare Supplement Application 128425, approved November 28, 2005. The following changes have been made:

1. The application has been reformatted which has resulted in numbering changes throughout the application.
2. Revised wording at the beginning of section 4.
3. Added dementia to question 6b.
4. Added new questions 1a and 6c.
5. Other minor editorial or verbiage changes.

Medicare Supplement Replacement Form 125593.1

Medicare Supplement Replacement Form 125593.1 will replace Medicare Supplement Replacement Form 125593 approved November 28, 2005. Minor editorial and verbiage changes have been made to the document.

Medicare Supplement Rates

Attached are the Medicare Supplement rates and actuarial memorandum for utilization with the 97037 HAR, 97038 HAR and 97039 HAR policies. These same rates were approved September 4, 2007 for use with the 97037 AR, 97038 AR and 97039 AR policies.

We will use the following previously approved forms with these policies:

SERFF Tracking Number:	*STFH-126337913*	*State:*	*Arkansas*
Filing Company:	*State Farm Mutual Automobile Insurance Company*	*State Tracking Number:*	*43748*
Company Tracking Number:	*97037 HAR, 97038 HAR, 97039 HAR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.003 Plan C 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*2010 Med Supp/97037 HAR, 97038 HAR, 97039 HAR*		

Form # Name of Form Approval Date

99005 Amendment of Application 06-29-70
99586.1-PW Important Notice Sticker 10-9-96

If you have any questions, please let us know.

Sincerely,
Barb Metz
Analyst – Health Contracts & Compliance
(309) 766-6544
FAX (309) 766-8483
Email – Barb.Metz.bfn5@statefarm.com
p.s. We are submitting a copy of the letter (form #121707.6) sent annually to advise insured's of the Medicare Deductible/Premium changes. This filing is for informational purposes only.

Company and Contact

Filing Contact Information

Barb Metz, Analyst - Contracts & Compliance	barb.metz.bfn5@statefarm.com	
1 State Farm Plaza	309-766-6544 [Phone]	
Bloomington, IL 61710-0001	309-766-8483 [FAX]	

Filing Company Information

State Farm Mutual Automobile Insurance Company	CoCode: 25178	State of Domicile: Illinois
One State Farm Plaza	Group Code:	Company Type:
Bloomington, IL 61710-0001	Group Name:	State ID Number:
(309) 735-2447 ext. [Phone]	FEIN Number: 37-0533100	

Filing Fees

Fee Required?	Yes
Fee Amount:	$450.00

SERFF Tracking Number:	*STFH-126337913*	*State:*	*Arkansas*
Filing Company:	*State Farm Mutual Automobile Insurance Company*	*State Tracking Number:*	*43748*
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Product Name:	*Medicare Supplement*		
Project Name/Number:	*2010 Med Supp/97037 HAR, 97038 HAR, 97039 HAR*		

Retaliatory?	Yes
Fee Explanation:	$50 x 6 forms = $300
	$50 x 3 sets of rates = $150
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
State Farm Mutual Automobile Insurance Company	$450.00	10/09/2009	31192781

SERFF Tracking Number:	*STFH-126337913*	*State:*	*Arkansas*
Filing Company:	*State Farm Mutual Automobile Insurance Company*	*State Tracking Number:*	*43748*
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Product Name:	*Medicare Supplement*		
Project Name/Number:	*2010 Med Supp/97037 HAR, 97038 HAR, 97039 HAR*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	12/16/2009	12/16/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Stephanie Fowler	12/01/2009	12/01/2009	Barb Metz	12/02/2009	12/02/2009

SERFF Tracking Number:	*STFH-126337913*	*State:*	*Arkansas*
Filing Company:	*State Farm Mutual Automobile Insurance Company*	*State Tracking Number:*	*43748*
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Project Name/Number:	*2010 Med Supp/97037 HAR, 97038 HAR, 97039 HAR*		

Disposition

Disposition Date: 12/16/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*STFH-126337913*	*State:*	*Arkansas*
Filing Company:	*State Farm Mutual Automobile Insurance Company*	*State Tracking Number:*	*43748*
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Project Name/Number:	*2010 Med Supp/97037 HAR, 97038 HAR, 97039 HAR*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Accepted for Informational Purposes	Yes
Supporting Document	Health - Actuarial Justification	Accepted for Informational Purposes	No
Supporting Document	Outline of Coverage	Accepted for Informational Purposes	Yes
Supporting Document	Annual Notice Letter	Accepted for Informational Purposes	Yes
Supporting Document	Actuarial Memorandum	Accepted for Informational Purposes	Yes
Supporting Document	Cover Letter	Accepted for Informational Purposes	Yes
Supporting Document	Actuarial Cover Letter	Accepted for Informational Purposes	No
Supporting Document	Important Notice Sticker	Accepted for Informational Purposes	Yes
Form	2010 Medicare Supplement Policy-Plan A	Approved	Yes
Form	2010 Medicare Supplement Policy-Plan C	Approved	Yes
Form	2010 Medicare Supplement Policy-Plan F	Approved	Yes
Form	Medicare Supplement Outline of Coverage	Approved	Yes
Form	Medicare Supplement Application	Approved	Yes
Form	Medicare Supplement Replacement Notice	Approved	Yes
Rate	AR Rates-Std 2010	Approved	Yes
Rate	AR Monthly Rates	Approved	Yes

SERFF Tracking Number:	*STFH-126337913*	*State:*	*Arkansas*
Filing Company:	*State Farm Mutual Automobile Insurance Company*	*State Tracking Number:*	*43748*
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Product Name:	*Medicare Supplement*		
Project Name/Number:	*2010 Med Supp/97037 HAR, 97038 HAR, 97039 HAR*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	12/01/2009
Submitted Date	12/01/2009
Respond By Date	01/01/2010

Dear Barb Metz,

This will acknowledge receipt of the captioned filing.

I am finishing up with my review of this filing, however, I will need a copy of the proposed base monthly rates by dollar amount to complete my review.

Please feel free to contact me if you have questions.
Sincerely,
Stephanie Fowler

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	12/02/2009
Submitted Date	12/02/2009

Dear Stephanie Fowler,

Comments:
We have received your recent correspondence.

Response 1

Comments: I have contacted our Actuary Department to obtain the following monthly Medicare Supplement Rates. Here's what was provided in response to your inquiry.

Changed Items:

No Supporting Documents changed.

SERFF Tracking Number:	*STFH-126337913*	*State:*	*Arkansas*
Filing Company:	*State Farm Mutual Automobile Insurance Company*	*State Tracking Number:*	*43748*
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Product Name:	*Medicare Supplement*		
Project Name/Number:	*2010 Med Supp/97037 HAR, 97038 HAR, 97039 HAR*		

No Form Schedule items changed.

Rate/Rule Schedule Item Changes

Document Name:	Affected Form Numbers:	Rate Action:	Rate Action Information:	Attach Document:
AR Monthly Rates	97037 HAR, 97039 HAR, 97038 HAR	New	*Previous State Filing Number* 0	

If you have any questions, please let me know.

Sincerely,
Barb Metz, Sandy Barnes

SERFF Tracking Number:	*STFH-126337913*	*State:*	*Arkansas*
Filing Company:	*State Farm Mutual Automobile Insurance Company*	*State Tracking Number:*	*43748*
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TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.003 Plan C 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*2010 Med Supp/97037 HAR, 97038 HAR, 97039 HAR*		

Form Schedule

Lead Form Number: 97037 HAR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 12/16/2009	97037 HAR	Policy/Contract/Fraternal Certificate	2010 Medicare Supplement Policy-Plan A	Initial		52.200	97037 HAR.PDF
Approved 12/16/2009	97038 HAR	Policy/Contract/Fraternal Certificate	2010 Medicare Supplement Policy-Plan C	Initial		50.200	97038 HAR.PDF
Approved 12/16/2009	97039 HAR	Policy/Contract/Fraternal Certificate	2010 Medicare Supplement Policy-Plan F	Initial		50.900	97039 HAR.PDF
Approved 12/16/2009	1002209	Outline of Coverage	Medicare Supplement Outline of Coverage	Initial		0.000	AR- Med. Supp. Outline of Coverage-1002209 (with [ ]'s).pdf
Approved 12/16/2009	1002336	Application/Enrollment Form	Medicare Supplement Application	Initial		60.400	1002336 AR.pdf
Approved 12/16/2009	125593.1	Other	Medicare Supplement Replacement Notice	Initial		0.000	s125593_1 (cw med supp repl not).pdf

STATE FARM MUTUAL
AUTOMOBILE INSURANCE COMPANY
Home Office/Bloomington, Illinois

INSURED

INITIAL PREMIUM

POLICY NUMBER

POLICY DATE

PREMIUM MODE

HEALTH
INSURANCE

We are pleased to issue this Medicare Supplement Policy to You. It was issued in consideration of Your application and payment of the required premium. We suggest You carefully read it.

We will pay the benefits stated in this policy subject to the provisions, limitations, and exceptions of the policy.

GUARANTEED RENEWABILITY

We will not refuse to renew Your policy except in the event of material misrepresentation in the application or nonpayment of premium when due. Any refusal to renew this policy shall be without prejudice to any claim for expenses incurred while this policy is in force or during a period of time when benefits are extended subject to the Extension and Limitation of Coverage provision.

YOUR PREMIUMS MAY BE CHANGED

We may change the table of premium rates for this policy at any time. Any such change shall apply only to premiums due on or after the effective date of change.

The amount due on each renewal date will be the renewal premium in Our table of premium rates for Your policy in effect at the time of such renewal.

Premiums may be changed to correspond with any changes made by the Federal Government to the Medicare program. Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts.

NOTICE TO BUYER

This policy may not cover all of Your medical expenses.

THIRTY DAY RIGHT TO EXAMINE POLICY

Please read this policy and the attached copy of the application carefully. If You do not want the policy for any reason, You may return it to Us or one of Our agents within thirty days after receipt. Upon return, the policy will be deemed void, and any money paid will be refunded.

Countersigned_____
Licensed Resident Agent

2010 MEDICARE SUPPLEMENT POLICY - PLAN A

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POLICY SCHEDULE

INSURED	[DOE, JOHN D.]	[$XXXX.XX]	INITIAL PREMIUM
POLICY NUMBER	[XXXXXXX XX]		
POLICY DATE	[JUNE 1, 2010]	[ANNUAL]	PREMIUM MODE

FIRST RENEWAL DATE: [JUNE 1, 2011]

THE BENEFITS AND PREMIUMS SHOWN ON THIS SCHEDULE ARE EFFECTIVE JUNE 1, 2010

FORM	COVERAGE SUMMARY	ANNUAL PREMIUM
97037 HAR	MEDICARE SUPPLEMENT POLICY – PLAN A	[$XXXX.XX]

BASIC BENEFITS

(1) PART A COINSURANCE AMOUNT FOR EACH DAY OF HOSPITAL CONFINEMENT FROM THE 61ST TO THE 90TH DAY

(2) PART A COINSURANCE AMOUNT FOR EACH LIFETIME RESERVE DAY USED

(3) ALL OF MEDICARE PART A ELIGIBLE EXPENSES AFTER MEDICARE INPATIENT COVERAGE IS EXHAUSTED – 365 DAYS LIFETIME MAXIMUM

(4) COVERAGE UNDER MEDICARE PARTS A AND B FOR THE REASONABLE COST OF THE FIRST THREE PINTS OF BLOOD

(5) PART A COINSURANCE AMOUNT FOR HOSPICE CARE

(6) PART B COINSURANCE AMOUNT FOR MEDICARE ELIGIBLE EXPENSES

FOR QUESTIONS, PROBLEMS OR TO OBTAIN INFORMATION ABOUT COVERAGE CONTACT

AGENT'S NAME
AGENT's ADDRESS
AGENT's PHONE #

ANNUAL RENEWAL PREMIUMS ON EACH RENEWAL DATE SUBJECT TO RENEWABILITY PROVISION ON PAGE 1.

(This page intentionally left blank)

GUIDE TO YOUR MEDICARE SUPPLEMENT POLICY
Table of Contents

The following is a Guide to Your Medicare Supplement Policy. It tells You what is included in Your policy and on what page(s) You can find it.

SECTION 1: IMPORTANT DEFINITIONS

Many words in Your policy have specific definitions. These words have been capitalized throughout Your policy for easy identification. This section defines these important terms.

Accidental Injury: means accidental bodily injury sustained by You which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while this policy is in force.

Benefit Period: begins the first day You receive service as an inpatient in a Hospital and ends after You have been out of the Hospital or Skilled Nursing Facility for 60 days in a row.

Coinsurance: means the Medicare eligible Part A and Part B expenses incurred to the extent not covered by Medicare.

Effective Date of Coverage: means the date when coverage starts under Your policy and is shown on the Policy Schedule. Coverage begins and ends at 12:01 A.M. in the area of Your residence.

Hospital: means a facility primarily engaged in providing inpatient services for medical diagnosis, treatment, and care of the injured, disabled, or sick and who meets the requirements for participation as determined by the Medicare program.

Medicare: means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses: means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Medicare Part A Inpatient Hospital Deductible: means the Medicare Part A deductible amount that is in effect when the Hospital insurance claim is incurred. This amount is determined each year by the Federal Government.

Physician: means a licensed practitioner of the healing arts performing services within the scope of his/her license as provided by the laws of the state in which he/she resides.

Policy Schedule: is the page of Your policy which lists important facts, such as the effective date of Your policy, the policy number, benefits, and premium information.

Sickness: means illness or disease which first manifests itself after the Effective Date of Coverage and while this policy is in force.

Skilled Nursing Facility: means a facility primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care; or rehabilitation services for the injured, disabled, or sick and who meets the requirements for participation as determined by the Medicare program.

Total Disability or Totally Disabled: means complete incapacity as the result of Your Accidental Injury or Sickness:

1. To engage in any occupation for pay or profit or, if not employed, to engage in the normal activities of a person of the same age; and
2. Which requires the regular care of a Physician other than Yourself.

We, Our, Us: means the State Farm Mutual Automobile Insurance Company, One State Farm Plaza, Bloomington, Illinois 61710-0001. Telephone number 866-855-1212

You, Your, Yourself: means the insured named on the Policy Schedule.

SECTION 2: BENEFIT PROVISIONS

For benefits payable under this policy, an expense is deemed to be incurred on the date of the service or purchase for which the charge is made. Benefits payable under this policy will not duplicate any benefits payable by Medicare.

Basic (Core) Benefits: We will provide the following basic benefits coverage for expenses incurred by You:

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period;
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
3. Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent (100%) of the Part A Medicare Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept our payment as payment in full and may not bill You for any balance;
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
5. Coverage for the Coinsurance amount (or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount) of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B deductible;
6. Hospice Care. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

If You are not insured under Medicare Part B, benefits will be paid as though You were insured under Medicare Part B.

SECTION 3: EXCLUSIONS, EXCEPTIONS AND LIMITATIONS

The following expenses are not eligible to be included in the calculation of benefits under this policy:

1. Expenses that are not eligible to be included in the calculation of benefits payable under Medicare.
2. Expenses incurred for confinement in a Hospital or Skilled Nursing Facility beginning before Your Effective Date of Coverage.
3. Charges which exceed the Medicare Eligible Expenses as specified in the Benefit Provisions.
4. Expenses incurred while the policy is not in force subject to the Extension and Limitation of Coverage provision.

SECTION 4: TERMINATION OF COVERAGE

Your Right to Request Cancellation: You have the right to cancel this policy at any time by written notice delivered or mailed to Us. Such cancellation will be effective upon receipt or on such later date as You state in such notice. We may waive these requirements by confirming the date and time of cancellation to You in writing. In this event, We will return promptly the pro rata unearned portion of any premium paid. Cancellation shall not affect any continuous loss that commenced while the policy was in force or during a period of time when benefits are extended, subject to the Extension and Limitation of Coverage provision.

Termination Due to Death: If You die while this policy is in force, Your policy will be cancelled on the day after Your death. Any unearned premium will be returned. The premium refund will be made payable to You or Your estate.

SECTION 5: EXTENSION AND LIMITATION OF COVERAGE

If You are Totally Disabled on Your coverage termination date, benefits provided by this policy will be limited to the duration of the policy Benefit Period, if any, or payment of the maximum benefits for the:

1. Accidental Injury or Sickness which caused the Total Disability; and
2. The expenses incurred for such Accidental Injury or Sickness during the uninterrupted continuance of Total Disability.

Such Accidental Injury or Sickness:

1. Must occur while the policy is in force; and
2. The expenses incurred for such Accidental Injury or Sickness must have been eligible to be included in the calculation of benefits payable under this policy and Medicare.

In no event will coverage be extended when You are no longer insured for coverage under Medicare.

SECTION 6: SUSPENSION OF COVERAGE

The benefits and premiums payable under Your policy will be suspended at Your request if either of the following occurs:

1. You apply for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. This suspension will be provided for a time period not to exceed twenty-four (24) months provided You notify Us within ninety (90) days after You become entitled to such assistance. Upon receipt of timely notice, We will return to You that portion of the premium attributable to Your period of Medicaid eligibility, subject to adjustment for paid claims.
2. You are entitled to benefits under Section 226(b) of the Social Security Act and are covered under an employee group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). This suspension will be for any period that may be provided by federal regulation.

If such suspension occurs and You lose entitlement to medical assistance or employee group health coverage, this policy will be automatically reinstated if:

1. You notify Us within ninety (90) days of losing coverage.
2. You pay the premium for this policy effective as of the date Your coverage for medical assistance or employee group health terminated.

Reinstitution of coverages shall:

1. Not be subject to any waiting period with respect to treatment of pre-existing conditions.

2. Provide coverage which is substantially equivalent to coverage in effect before the date this policy was suspended; and
3. Provide for classification of premiums on terms at least as favorable to **You** as the terms that would have applied had this policy not been suspended.

SECTION 7: PREMIUM PAYMENT

This section discusses issues like premium payment, importance of paying premiums on time, what happens if premiums are not paid.

Paying Premiums: Premiums are to be paid with United States currency. They are due at the beginning of each policy term. Payment may be made to Us or to Your agent. You can change the policy term if You notify Us in writing and it is agreed upon by You and Us.

Installment Privileges: You may elect to pay any premium due in installments agreed upon by You and Us. Failure to pay any installments when due or within the grace period shall be construed to be a request to cancel this policy effective on the last day of such grace period.

Grace Period: This policy has a 31 day grace period. During the grace period, the policy will stay in force. This means that if any premium or installment thereof is not paid on or before the date it is due, it may be paid during the following 31 days.

Reinstatement: If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by Us or by an agent expressly authorized to accept payment without requiring an application for reinstatement will reinstate the policy.

If We or Our agent requires an application, You will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Unless we have previously written You of Our disapproval, the policy will be reinstated on the 45th day after the date of the conditional receipt.

The reinstated policy will cover only loss that results from an Accidental Injury sustained after the date of reinstatement or Sickness that starts more than 10 days after such date. In other respects Your and Our rights remain the same, subject to any provisions noted on or attached to the reinstated policy.

Any premiums We accept for a reinstatement will be applied to a period for which premiums have not been paid. No premium will be applied to any period more than 60 days before the reinstatement date.

Unpaid Premium: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

SECTION 8: CLAIMS

This section describes how to notify Us of a claim, how and when to file a claim, how and when Your claim is paid and other rights and responsibilities under the policy.

Notice of Claim: You must notify Us or Your agent in writing of a claim within 30 days after a covered loss begins, or as soon as reasonably possible. Notice given to Us by You or on Your behalf with information sufficient to identify You as the insured, shall be deemed notice.

Claim Forms: We will send You appropriate claim forms within 15 days of receiving Your notice of claim. If We do not, You will meet the requirements of providing Us with written proof of loss by sending Us a written statement describing the type and nature of Your loss.

Proof of Loss: You should send us written proof of loss within 90 days after the end of the time period in which You were treated. If this is not possible, Your claim will not be affected. However, unless You are legally incapable, You must notify Us within one (1) year from the time proof is otherwise required.

Time of Payment of Claims: Indemnities payable under this policy will be paid upon receipt of proper written proof of such loss.

Payment of Claims: Benefits will be paid to You unless subject to a valid assignment of benefits. Accrued benefits unpaid at Your death will be paid to Your estate.

If benefits are payable to Your estate, We may pay benefits up to $ 1,000 to a person related to You by blood or marriage whom We consider to be entitled to the benefits. We shall be discharged to the extent of any such payment made in good faith.

Physical Examination and Autopsy: We have the right to have You examined at Our expense as often as reasonably necessary while a claim is pending. We may also have an autopsy done unless prohibited by law.

Legal Actions: No legal action may be brought to recover on this policy within 60 days after written Proof of Loss has been given as required by this policy. No such action may be brought after 3 years from the time written Proof of Loss is required to be given.

Assignment: No assignment of interest under this policy shall be binding upon Us until it is received by Us. We do not assume any responsibility for the validity of an assignment.

Conformity with State Statutes: Any provision of this policy which, on the Effective Date of Coverage, is in conflict with the laws of the state in which You reside on that date is amended to conform to the minimum requirements of such laws.

SECTION 9: THE CONTRACT

This section identifies the documents which describe all contractual agreements, the importance of accurate and truthful application completion, and other basic rights, obligations, and features.

Entire Contract: This policy, application and the attached papers constitutes the entire contract of insurance between You and Us. The contract is made up of:

1. The policy.
2. The application; and
3. The attached papers.

No change in this policy will be effective until approved in writing by one of Our officers.

No agent may change this policy or waive any of its provisions.

Time Limit on Certain Defenses:

1. **Misstatements in the Application**: After two years from the Effective Date of Coverage only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred after such two year period.

2. **Converted Policy**: If this policy is issued as the result of Your exercising a conversion privilege provided under any other health insurance policy issued by Us, the time periods specified in this Time Limit on Certain Defenses provision shall be deemed to have commenced on the Effective Date of Coverage for You under the policy from which the conversion occurred.

SECTION 10: MUTUAL CONDITIONS

1. Membership, While this policy is in force, You are entitled to vote at all meetings of members and to receive dividends the Board of Directors in its discretion may declare in accordance with reasonable classifications and groupings of policy holders established by such Board.

2. No Contingent Liability. This policy is non-assessable.

3. Annual Meeting. The annual meeting of the members of the company shall be held at its home office at Bloomington, Illinois, on the second Monday of June at the hour of 10:00 A.M., unless the Board of Directors shall elect to change the time and place of such meeting, in which case, but not otherwise, due notice shall be mailed to each member at the address disclosed in this policy at least 10 days prior thereto.

IN WITNESS WHEREOF, THE STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY has caused this policy to be signed by its President and Secretary at Bloomington, Illinois, and countersigned on page one by a duly licensed resident agent of the Company.

Kim M. Brunner

Secretary

Vincent J. Trosino

President

STATE FARM MUTUAL
AUTOMOBILE INSURANCE COMPANY
Home Office/Bloomington, Illinois

INSURED

INITIAL PREMIUM

POLICY NUMBER

POLICY DATE

PREMIUM MODE

HEALTH
INSURANCE

We are pleased to issue this Medicare Supplement Policy to You. It was issued in consideration of Your application and payment of the required premium. We suggest You carefully read it.

We will pay the benefits stated in this policy subject to the provisions, limitations, and exceptions of the policy.

GUARANTEED RENEWABILITY

We will not refuse to renew Your policy except in the event of material misrepresentation in the application or nonpayment of premium when due. Any refusal to renew this policy shall be without prejudice to any claim for expenses incurred while this policy is in force or during a period of time when benefits are extended subject to the Extension and Limitation of Coverage provision.

YOUR PREMIUMS MAY BE CHANGED

We may change the table of premium rates for this policy at any time. Any such change shall apply only to premiums due on or after the effective date of change.

The amount due on each renewal date will be the renewal premium in Our table of premium rates for Your policy in effect at the time of such renewal.

Premiums may be changed to correspond with any changes made by the Federal Government to the Medicare program. Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts.

NOTICE TO BUYER

This policy may not cover all of Your medical expenses.

THIRTY DAY RIGHT TO EXAMINE POLICY

Please read this policy and the attached copy of the application carefully. If You do not want the policy for any reason, You may return it to Us or one of Our agents within thirty days after receipt. Upon return, the policy will be deemed void, and any money paid will be refunded.

Countersigned_____
Licensed Resident Agent

2010 MEDICARE SUPPLEMENT POLICY - PLAN C

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POLICY SCHEDULE

INSURED [DOE, JOHN D.] [$XXXX.XX] INITIAL PREMIUM

POLICY NUMBER [HXXXXXXX XX]

POLICY DATE [JUNE 1, 2010] [ANNUAL] PREMIUM MODE

FIRST RENEWAL DATE: [JUNE 1, 2011]

THE BENEFITS AND PREMIUMS SHOWN ON THIS SCHEDULE ARE EFFECTIVE JUNE 1, 2010

FORM	COVERAGE SUMMARY	ANNUAL PREMIUM
97038 HAR	MEDICARE SUPPLEMENT POLICY – PLAN C	[$XXXX.XX]

BASIC BENEFITS

(1) PART A COINSURANCE AMOUNT FOR EACH DAY OF HOSPITAL CONFINEMENT FROM THE 61ST TO THE 90TH DAY
(2) PART A COINSURANCE AMOUNT FOR EACH LIFETIME RESERVE DAY USED
(3) ALL OF MEDICARE PART A ELIGIBLE EXPENSES AFTER MEDICARE INPATIENT COVERAGE IS EXHAUSTED – 365 DAYS LIFETIME MAXIMUM
(4) COVERAGE UNDER MEDICARE PARTS A AND B FOR THE REASONABLE COST OF THE FIRST THREE PINTS OF BLOOD
(5) PART A COINSURANCE AMOUNT FOR HOSPICE CARE
(6) PART B COINSURANCE AMOUNT FOR MEDICARE ELIGIBLE EXPENSES

ADDITIONAL BENEFITS

(1) MEDICARE PART A INPATIENT HOSPITAL DEDUCTIBLE AMOUNT
(2) PART A COINSURANCE AMOUNT FROM THE 21ST TO THE 100TH DAY FOR CONFINEMENT IN A SKILLED NURSING FACILITY
(3) MEDICARE PART B DEDUCTIBLE AMOUNT
(4) MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY
    80% OF CHARGES AFTER $250 DEDUCTIBLE PER CALENDAR YEAR -- $50,000 LIFETIME MAXIMUM

FOR QUESTIONS, PROBLEMS OR TO OBTAIN INFORMATION ABOUT COVERAGE CONTACT

AGENT'S NAME
AGENT's ADDRESS
AGENT's PHONE #

ANNUAL RENEWAL PREMIUMS ON EACH RENEWAL DATE SUBJECT TO RENEWABILITY PROVISION ON PAGE 1.

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GUIDE TO YOUR MEDICARE SUPPLEMENT POLICY
Table of Contents

The following is a Guide to Your Medicare Supplement Policy. It tells You what is included in Your policy and on what page(s) You can find it.

SECTION 1: IMPORTANT DEFINITIONS

Many words in Your policy have specific definitions. These words have been capitalized throughout Your policy for easy identification. This section defines these important terms.

Accidental Injury: means accidental bodily injury sustained by You which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while this policy is in force.

Benefit Period: begins the first day You receive service as an inpatient in a Hospital and ends after You have been out of the Hospital or Skilled Nursing Facility for 60 days in a row.

Coinsurance: means the Medicare eligible Part A and Part B expenses incurred to the extent not covered by Medicare.

Effective Date of Coverage: means the date when coverage starts under Your policy and is shown on the Policy Schedule. Coverage begins and ends at 12:01 A.M. in the area of Your residence.

Hospital: means a facility primarily engaged in providing inpatient services for medical diagnosis, treatment, and care of the injured, disabled, or sick and who meets the requirements for participation as determined by the Medicare program.

Medicare: means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses: means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Medicare Part A Inpatient Hospital Deductible: means the Medicare Part A deductible amount that is in effect when the Hospital insurance claim is incurred. This amount is determined each year by the Federal Government.

Medicare Part B Deductible: means the Medicare Part B deductible amount that is in effect when the insurance claim is incurred. This amount is determined each year by the Federal Government.

Physician: means a licensed practitioner of the healing arts performing services within the scope of his/her license as provided by the laws of the state in which he/she resides.

Policy Schedule: is the page of Your policy which lists important facts, such as the effective date of Your policy, the policy number, benefits, and premium information.

Sickness: means illness or disease which first manifests itself after the Effective Date of Coverage and while this policy is in force.

Skilled Nursing Facility: means a facility primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care; or rehabilitation services for the injured, disabled, or sick and who meets the requirements for participation as determined by the Medicare program.

Total Disability or Totally Disabled: means complete incapacity as the result of Your Accidental Injury or Sickness:

1. To engage in any occupation for pay or profit or, if not employed, to engage in the normal activities of a person of the same age; and
2. Which requires the regular care of a Physician other than Yourself.

We, Our, Us: means the State Farm Mutual Automobile Insurance Company, One State Farm Plaza, Bloomington, Illinois 61710-0001. Telephone number 866-855-1212

You, Your, Yourself: means the insured named on the Policy Schedule.

SECTION 2: BENEFIT PROVISIONS

For benefits payable under this policy, an expense is deemed to be incurred on the date of the service or purchase for which the charge is made. Benefits payable under this policy will not duplicate any benefits payable by Medicare.

Basic (Core) Benefits: We will provide the following basic benefits coverage for expenses incurred by You:

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period;
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
3. Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent (100%) of the Part A Medicare Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept our payment as payment in full and may not bill You for any balance;
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
5. Coverage for the Coinsurance amount (or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount) of Medicare Eligible Expenses under Part B regardless of Hospital confinement; subject to the Medicare Part B deductible;
6. Hospice Care. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

Additional Benefits: We will provide the following additional benefits for expenses incurred by You:

1. Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A Inpatient Hospital Deductible amount per Benefit Period.
2. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day though the 100th day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility care eligible under Medicare Part A.
3. Medicare Part B Deductible: Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of Hospital confinement.
4. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of injury or an illness of sudden and unexpected onset.

If You are not insured under Medicare Part B, benefits will be paid as though You were insured under Medicare Part B.

SECTION 3: EXCLUSIONS, EXCEPTIONS AND LIMITATIONS

The following expenses are not eligible to be included in the calculation of benefits under this policy:

1. Expenses that are not eligible to be included in the calculation of benefits payable under Medicare except for those benefits payable under the Medically Necessary Emergency Care in a Foreign Country benefit.
2. Expenses incurred for confinement in a Hospital or Skilled Nursing Facility beginning before Your Effective Date of Coverage.
3. Charges which exceed the Medicare Eligible Expenses as specified in the Benefit Provisions.
4. Expenses incurred while the policy is not in force subject to the Extension and Limitation of Coverage provision.
5. Expenses incurred for non-emergency care or treatment while traveling in a country where Medicare benefits are not payable.

SECTION 4: TERMINATION OF COVERAGE

Your Right to Request Cancellation: You have the right to cancel this policy at any time by written notice delivered or mailed to Us. Such cancellation will be effective upon receipt or on such later date as You state in such notice. We may waive these requirements by confirming the date and time of cancellation to You in writing. In this event, We will return promptly the pro rata unearned portion of any premium paid. Cancellation shall not affect any continuous loss that commenced while the policy was in force or during a period of time when benefits are extended, subject to the Extension and Limitation of Coverage provision.

Termination Due to Death: If You die while this policy is in force, Your policy will be cancelled on the day after Your death. Any unearned premium will be returned. The premium refund will be made payable to You or Your estate.

SECTION 5: EXTENSION AND LIMITATION OF COVERAGE

If You are Totally Disabled on Your coverage termination date, benefits provided by this policy will be limited to the duration of the policy Benefit Period, if any, or payment of the maximum benefits for the:

1. Accidental Injury or Sickness which caused the Total Disability; and
2. The expenses incurred for such Accidental Injury or Sickness during the uninterrupted continuance of Total Disability.

Such Accidental Injury or Sickness:

1. Must occur while the policy is in force; and
2. The expenses incurred for such Accidental Injury or Sickness must have been eligible to be included in the calculation of benefits payable under this policy and Medicare.

In no event will coverage be extended when You are no longer insured for coverage under Medicare.

SECTION 6: SUSPENSION OF COVERAGE

The benefits and premiums payable under Your policy will be suspended at Your request if either of the following occurs:

1. You apply for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. This suspension will be provided for a time period not to exceed twenty-four (24) months provided You notify Us within ninety (90) days after You become entitled to such assistance. Upon receipt of timely notice, We will return to You that portion of the premium attributable to Your period of Medicaid eligibility, subject to adjustment for paid claims.
2. You are entitled to benefits under Section 226(b) of the Social Security Act and are covered under an employee group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). This suspension will be for any period that may be provided by federal regulation.

If such suspension occurs and You lose entitlement to medical assistance or employee group health coverage, this policy will be automatically reinstated if:

1. You notify Us within ninety (90) days of losing coverage.
2. You pay the premium for this policy effective as of the date Your coverage for medical assistance or employee group health terminated.

Reinstitution of coverages shall:

1. Not be subject to any waiting period with respect to treatment of pre-existing conditions.
2. Provide coverage which is substantially equivalent to coverage in effect before the date this policy was suspended; and
3. Provide for classification of premiums on terms at least as favorable to **You** as the terms that would have applied had this policy not been suspended.

SECTION 7: PREMIUM PAYMENT

This section discusses issues like premium payment, importance of paying premiums on time, what happens if premiums are not paid.

Paying Premiums: Premiums are to be paid with United States currency. They are due at the beginning of each policy term. Payment may be made to Us or to Your agent. You can change the policy term if You notify Us in writing and it is agreed upon by You and Us.

Installment Privileges:You may elect to pay any premium due in installments agreed upon by You and Us. Failure to pay any installments when due or within the grace period shall be construed to be a request to cancel this policy effective on the last day of such grace period.

Grace Period: This policy has a 31 day grace period. During the grace period, the policy will stay in force. This means that if any premium or installment thereof is not paid on or before the date it is due, it may be paid during the following 31 days.

Reinstatement: If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by Us or by an agent expressly authorized to accept payment without requiring an application for reinstatement will reinstate the policy.

If We or Our agent requires an application, You will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Unless we have previously written You of Our disapproval, the policy will be reinstated on the 45th day after the date of the conditional receipt.

The reinstated policy will cover only loss that results from an Accidental Injury sustained after the date of reinstatement or Sickness that starts more than 10 days after such date. In other respects Your and Our rights remain the same, subject to any provisions noted on or attached to the reinstated policy.

Any premiums We accept for a reinstatement will be applied to a period for which premiums have not been paid. No premium will be applied to any period more than 60 days before the reinstatement date.

Unpaid Premium: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

SECTION 8: CLAIMS

This section describes how to notify Us of a claim, how and when to file a claim, how and when Your claim is paid and other rights and responsibilities under the policy.

Notice of Claim: You must notify Us or Your agent in writing of a claim within 30 days after a covered loss begins, or as soon as reasonably possible. Notice given to Us by You or on Your behalf with information sufficient to identify You as the insured, shall be deemed notice.

Claim Forms: We will send You appropriate claim forms within 15 days of receiving Your notice of claim. If We do not, You will meet the requirements of providing Us with written proof of loss by sending Us a written statement describing the type and nature of Your loss.

Proof of Loss: You should send us written proof of loss within 90 days after the end of the time period in which You were treated. If this is not possible, Your claim will not be affected. However, unless You are legally incapable, You must notify Us within one (1) year from the time proof is otherwise required.

Time of Payment of Claims: Indemnities payable under this policy will be paid upon receipt of proper written proof of such loss.

Payment of Claims: Benefits will be paid to You unless subject to a valid assignment of benefits. Accrued benefits unpaid at Your death will be paid to Your estate.

If benefits are payable to Your estate, We may pay benefits up to $ 1,000 to a person related to You by blood or marriage whom We consider to be entitled to the benefits. We shall be discharged to the extent of any such payment made in good faith.

Physical Examination and Autopsy: We have the right to have You examined at Our expense as often as reasonably necessary while a claim is pending. We may also have an autopsy done unless prohibited by law.

Legal Actions: No legal action may be brought to recover on this policy within 60 days after written Proof of Loss has been given as required by this policy. No such action may be brought after 3 years from the time written Proof of Loss is required to be given.

Assignment: No assignment of interest under this policy shall be binding upon Us until it is received by Us. We do not assume any responsibility for the validity of an assignment.

Conformity with State Statutes: Any provision of this policy which, on the Effective Date of Coverage, is in conflict with the laws of the state in which You reside on that date is amended to conform to the minimum requirements of such laws.

SECTION 9: THE CONTRACT

This section identifies the documents which describe all contractual agreements, the importance of accurate and truthful application completion, and other basic rights, obligations, and features.

Entire Contract: This policy, application and the attached papers constitutes the entire contract of insurance between You and Us. The contract is made up of:

1. The policy.
2. The application; and
3. The attached papers.

No change in this policy will be effective until approved in writing by one of Our officers.

No agent may change this policy or waive any of its provisions.

Time Limit on Certain Defenses:

1. **Misstatements in the Application:** After two years from the Effective Date of Coverage only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred after such two year period.

2. **Converted Policy:** If this policy is issued as the result of Your exercising a conversion privilege provided under any other health insurance policy issued by Us, the time periods specified in this Time Limit on Certain Defenses provision shall be deemed to have commenced on the Effective Date of Coverage for You under the policy from which the conversion occurred.

SECTION 10: MUTUAL CONDITIONS

1. Membership, While this policy is in force, You are entitled to vote at all meetings of members and to receive dividends the Board of Directors in its discretion may declare in accordance with reasonable classifications and groupings of policy holders established by such Board.

2. No Contingent Liability. This policy is non-assessable.

3. Annual Meeting. The annual meeting of the members of the company shall be held at its home office at Bloomington, Illinois, on the second Monday of June at the hour of 10:00 A.M., unless the Board of Directors shall elect to change the time and place of such meeting, in which case, but not otherwise, due notice shall be mailed to each member at the address disclosed in this policy at least 10 days prior thereto.

IN WITNESS WHEREOF, THE STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY has caused this policy to be signed by its President and Secretary at Bloomington, Illinois, and countersigned on page one by a duly licensed resident agent of the Company.

Kim M. Brunner

Secretary

Vincent J. Trosino

President

STATE FARM MUTUAL
AUTOMOBILE INSURANCE COMPANY
Home Office/Bloomington, Illinois

INSURED

INITIAL PREMIUM

POLICY NUMBER

POLICY DATE

PREMIUM MODE

HEALTH
INSURANCE

We are pleased to issue this Medicare Supplement Policy to You. It was issued in consideration of Your application and payment of the required premium. We suggest You carefully read it.

We will pay the benefits stated in this policy subject to the provisions, limitations, and exceptions of the policy.

GUARANTEED RENEWABILITY

We will not refuse to renew Your policy except in the event of material misrepresentation in the application or nonpayment of premium when due. Any refusal to renew this policy shall be without prejudice to any claim for expenses incurred while this policy is in force or during a period of time when benefits are extended subject to the Extension and Limitation of Coverage provision.

YOUR PREMIUMS MAY BE CHANGED

We may change the table of premium rates for this policy at any time. Any such change shall apply only to premiums due on or after the effective date of change.

The amount due on each renewal date will be the renewal premium in Our table of premium rates for Your policy in effect at the time of such renewal.

Premiums may be changed to correspond with any changes made by the Federal Government to the Medicare program. Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts.

NOTICE TO BUYER

This policy may not cover all of Your medical expenses.

THIRTY DAY RIGHT TO EXAMINE POLICY

Please read this policy and the attached copy of the application carefully. If You do not want the policy for any reason, You may return it to Us or one of Our agents within thirty days after receipt. Upon return, the policy will be deemed void, and any money paid will be refunded.

Countersigned_____
Licensed Resident Agent

2010 MEDICARE SUPPLEMENT POLICY - PLAN F

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POLICY SCHEDULE

INSURED	[DOE, JOHN D.]	[$XXXX.XX]	INITIAL PREMIUM
POLICY NUMBER	[XXXXXXX XX]		
POLICY DATE	[June 1, 2010]	[ANNUAL]	PREMIUM MODE

FIRST RENEWAL DATE: [June 1, 2011]

THE BENEFITS AND PREMIUMS SHOWN ON THIS SCHEDULE ARE EFFECTIVE [JUNE 1, 2010]

FORM	COVERAGE SUMMARY	ANNUAL PREMIUM
97039 HAR	MEDICARE SUPPLEMENT POLICY – PLAN F	[$XXXX.XX]

BASIC BENEFITS

(1) PART A COINSURANCE AMOUNT FOR EACH DAY OF HOSPITAL CONFINEMENT FROM THE 61ST TO THE 90TH DAY
(2) PART A COINSURANCE AMOUNT FOR EACH LIFETIME RESERVE DAY USED
(3) ALL OF MEDICARE PART A ELIGIBLE EXPENSES AFTER MEDICARE INPATIENT COVERAGE IS EXHAUSTED – 365 DAYS LIFETIME MAXIMUM
(4) COVERAGE UNDER MEDICARE PARTS A AND B FOR THE REASONABLE COST OF THE FIRST THREE PINTS OF BLOOD
(5) PART A COINSURANCE AMOUNT FOR HOSPICE CARE
(6) PART B COINSURANCE AMOUNT FOR MEDICARE ELIGIBLE EXPENSES

ADDITIONAL BENEFITS

(1) MEDICARE PART A INPATIENT HOSPITAL DEDUCTIBLE AMOUNT
(2) PART A COINSURANCE AMOUNT FROM THE 21ST TO THE 100TH DAY FOR CONFINEMENT IN A SKILLED NURSING FACILITY
(3) MEDICARE PART B DEDUCTIBLE AMOUNT
(4) 100% OF MEDICARE PART B EXCESS CHARGES IF ASSIGNMENT NOT ACCEPTED
(5) MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY
    80% OF CHARGES AFTER $250 DEDUCTIBLE PER CALENDAR YEAR -- $50,000 LIFETIME MAXIMUM

FOR QUESTIONS, PROBLEMS OR TO OBTAIN INFORMATION ABOUT COVERAGE CONTACT

AGENT'S NAME
AGENT's ADDRESS
AGENT's PHONE #

ANNUAL RENEWAL PREMIUMS ON EACH RENEWAL DATE SUBJECT TO RENEWABILITY PROVISION ON PAGE 1.

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GUIDE TO YOUR MEDICARE SUPPLEMENT POLICY
Table of Contents

The following is a Guide to Your Medicare Supplement Policy. It tells You what is included in Your policy and on what page(s) You can find it.

SECTION 1: IMPORTANT DEFINITIONS

Many words in Your policy have specific definitions. These words have been capitalized throughout Your policy for easy identification. This section defines these important terms.

Accidental Injury: means accidental bodily injury sustained by You which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while this policy is in force.

Benefit Period: begins the first day You receive service as an inpatient in a Hospital and ends after You have been out of the Hospital or Skilled Nursing Facility for 60 days in a row.

Coinsurance: means the Medicare eligible Part A and Part B expenses incurred to the extent not covered by Medicare.

Effective Date of Coverage: means the date when coverage starts under Your policy and is shown on the Policy Schedule. Coverage begins and ends at 12:01 A.M. in the area of Your residence.

Hospital: means a facility primarily engaged in providing inpatient services for medical diagnosis, treatment, and care of the injured, disabled, or sick and who meets the requirements for participation as determined by the Medicare program.

Medicare: means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses: means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Medicare Part A Inpatient Hospital Deductible: means the Medicare Part A deductible amount that is in effect when the Hospital insurance claim is incurred. This amount is determined each year by the Federal Government.

Medicare Part B Deductible: means the Medicare Part B deductible amount that is in effect when the insurance claim is incurred. This amount is determined each year by the Federal Government.

Physician: means a licensed practitioner of the healing arts performing services within the scope of his/her license as provided by the laws of the state in which he/she resides.

Policy Schedule: is the page of Your policy which lists important facts, such as the effective date of Your policy, the policy number, benefits, and premium information.

Sickness: means illness or disease which first manifests itself after the Effective Date of Coverage and while this policy is in force.

Skilled Nursing Facility: means a facility primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care; or rehabilitation services for the injured, disabled, or sick and who meets the requirements for participation as determined by the Medicare program.

Total Disability or Totally Disabled: means complete incapacity as the result of Your Accidental Injury or Sickness:

1. To engage in any occupation for pay or profit or, if not employed, to engage in the normal activities of a person of the same age; and
2. Which requires the regular care of a Physician other than Yourself.

We, Our, Us: means the State Farm Mutual Automobile Insurance Company, One State Farm Plaza, Bloomington, Illinois 61710-0001. Telephone number 866-855-1212

You, Your, Yourself: means the insured named on the Policy Schedule.

SECTION 2: BENEFIT PROVISIONS

For benefits payable under this policy, an expense is deemed to be incurred on the date of the service or purchase for which the charge is made. Benefits payable under this policy will not duplicate any benefits payable by Medicare.

Basic (Core) Benefits: We will provide the following basic benefits coverage for expenses incurred by You:

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period;
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
3. Upon exhaustion of the Medicare Hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent (100%) of the Part A Medicare Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept our payment as payment in full and may not bill You for any balance;
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
5. Coverage for the Coinsurance amount (or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount) of Medicare Eligible Expenses under Part B regardless of Hospital confinement; subject to the Medicare Part B deductible;
6. Hospice Care. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

Additional Benefits: We will provide the following additional benefits for expenses incurred by You:

1. Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A Inpatient Hospital Deductible amount per Benefit Period.
2. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day though the 100th day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility care eligible under Medicare Part A.
3. Medicare Part B Deductible: Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of Hospital confinement.
4. One hundred percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
5. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of injury or an illness of sudden and unexpected onset.

If You are not insured under Medicare Part B, benefits will be paid as though You were insured under Medicare Part B.

SECTION 3: EXCLUSIONS, EXCEPTIONS AND LIMITATIONS

The following expenses are not eligible to be included in the calculation of benefits under this policy:

1. Expenses that are not eligible to be included in the calculation of benefits payable under Medicare except for those benefits payable under the Medically Necessary Emergency Care in a Foreign Country benefit.
2. Expenses incurred for confinement in a Hospital or Skilled Nursing Facility beginning before Your Effective Date of Coverage.
3. Charges which exceed the Medicare Eligible Expenses except as specified in the Benefit Provisions.
4. Expenses incurred while the policy is not in force subject to the Extension and Limitation of Coverage provision.
5. Expenses incurred for non-emergency care or treatment while traveling in a country where Medicare benefits are not payable.

SECTION 4: TERMINATION OF COVERAGE

Your Right to Request Cancellation: You have the right to cancel this policy at any time by written notice delivered or mailed to Us. Such cancellation will be effective upon receipt or on such later date as You state in such notice. We may waive these requirements by confirming the date and time of cancellation to You in writing. In this event, We will return promptly the pro rata unearned portion of any premium paid. Cancellation shall not affect any continuous loss that commenced while the policy was in force or during a period of time when benefits are extended, subject to the Extension and Limitation of Coverage provision.

Termination Due to Death: If You die while this policy is in force, Your policy will be cancelled on the day after Your death. Any unearned premium will be returned. The premium refund will be made payable to You or Your estate.

SECTION 5: EXTENSION AND LIMITATION OF COVERAGE

If You are Totally Disabled on Your coverage termination date, benefits provided by this policy will be limited to the duration of the policy Benefit Period, if any, or payment of the maximum benefits for the:

1. Accidental Injury or Sickness which caused the Total Disability; and
2. The expenses incurred for such Accidental Injury or Sickness during the uninterrupted continuance of Total Disability.

Such Accidental Injury or Sickness:

1. Must occur while the policy is in force; and
2. The expenses incurred for such Accidental Injury or Sickness must have been eligible to be included in the calculation of benefits payable under this policy and Medicare.

In no event will coverage be extended when You are no longer insured for coverage under Medicare.

SECTION 6: SUSPENSION OF COVERAGE

The benefits and premiums payable under Your policy will be suspended at Your request if either of the following occurs:

1. You apply for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. This suspension will be provided for a time period not to exceed twenty-four (24) months provided You notify Us within ninety (90) days after You become entitled to such assistance. Upon receipt of timely notice, We will return to You that portion of the premium attributable to Your period of Medicaid eligibility, subject to adjustment for paid claims.
2. You are entitled to benefits under Section 226(b) of the Social Security Act and are covered under an employee group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). This suspension will be for any period that may be provided by federal regulation.

If such suspension occurs and You lose entitlement to medical assistance or employee group health coverage, this policy will be automatically reinstated if:

1. You notify Us within ninety (90) days of losing coverage.
2. You pay the premium for this policy effective as of the date Your coverage for medical assistance or employee group health terminated.

Reinstitution of coverages shall:

1. Not be subject to any waiting period with respect to treatment of pre-existing conditions.
2. Provide coverage which is substantially equivalent to coverage in effect before the date this policy was suspended; and
3. Provide for classification of premiums on terms at least as favorable to **You** as the terms that would have applied had this policy not been suspended.

SECTION 7: PREMIUM PAYMENT

This section discusses issues like premium payment, importance of paying premiums on time, what happens if premiums are not paid.

Paying Premiums: Premiums are to be paid with United States currency. They are due at the beginning of each policy term. Payment may be made to Us or to Your agent. You can change the policy term if You notify Us in writing and it is agreed upon by You and Us.

Installment Privileges:You may elect to pay any premium due in installments agreed upon by You and Us. Failure to pay any installments when due or within the grace period shall be construed to be a request to cancel this policy effective on the last day of such grace period.

Grace Period: This policy has a 31 day grace period. During the grace period, the policy will stay in force. This means that if any premium or installment thereof is not paid on or before the date it is due, it may be paid during the following 31 days.

Reinstatement: If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by Us or by an agent expressly authorized to accept payment without requiring an application for reinstatement will reinstate the policy.

If We or Our agent requires an application, You will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Unless we have previously written You of Our disapproval, the policy will be reinstated on the 45th day after the date of the conditional receipt.

The reinstated policy will cover only loss that results from an Accidental Injury sustained after the date of reinstatement or Sickness that starts more than 10 days after such date. In other respects Your and Our rights remain the same, subject to any provisions noted on or attached to the reinstated policy.

Any premiums We accept for a reinstatement will be applied to a period for which premiums have not been paid. No premium will be applied to any period more than 60 days before the reinstatement date.

Unpaid Premium: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

SECTION 8: CLAIMS

This section describes how to notify Us of a claim, how and when to file a claim, how and when Your claim is paid and other rights and responsibilities under the policy.

Notice of Claim: You must notify Us or Your agent in writing of a claim within 30 days after a covered loss begins, or as soon as reasonably possible. Notice given to Us by You or on Your behalf with information sufficient to identify You as the insured, shall be deemed notice.

Claim Forms: We will send You appropriate claim forms within 15 days of receiving Your notice of claim. If We do not, You will meet the requirements of providing Us with written proof of loss by sending Us a written statement describing the type and nature of Your loss.

Proof of Loss: You should send us written proof of loss within 90 days after the end of the time period in which You were treated. If this is not possible, Your claim will not be affected. However, unless You are legally incapable, You must notify Us within one (1) year from the time proof is otherwise required.

Time of Payment of Claims: Indemnities payable under this policy will be paid upon receipt of proper written proof of such loss.

Payment of Claims: Benefits will be paid to You unless subject to a valid assignment of benefits. Accrued benefits unpaid at Your death will be paid to Your estate.

If benefits are payable to Your estate, We may pay benefits up to $ 1,000 to a person related to You by blood or marriage whom We consider to be entitled to the benefits. We shall be discharged to the extent of any such payment made in good faith.

Physical Examination and Autopsy: We have the right to have You examined at Our expense as often as reasonably necessary while a claim is pending. We may also have an autopsy done unless prohibited by law.

Legal Actions: No legal action may be brought to recover on this policy within 60 days after written Proof of Loss has been given as required by this policy. No such action may be brought after 3 years from the time written Proof of Loss is required to be given.

Assignment: No assignment of interest under this policy shall be binding upon Us until it is received by Us. We do not assume any responsibility for the validity of an assignment.

Conformity with State Statutes: Any provision of this policy which, on the Effective Date of Coverage, is in conflict with the laws of the state in which You reside on that date is amended to conform to the minimum requirements of such laws.

SECTION 9: THE CONTRACT

This section identifies the documents which describe all contractual agreements, the importance of accurate and truthful application completion, and other basic rights, obligations, and features.

Entire Contract: This policy, application and the attached papers constitutes the entire contract of insurance between You and Us. The contract is made up of:

1. The policy.
2. The application; and
3. The attached papers.

No change in this policy will be effective until approved in writing by one of Our officers.

No agent may change this policy or waive any of its provisions.

Time Limit on Certain Defenses:

1. **Misstatements in the Application:** After two years from the Effective Date of Coverage only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred after such two year period.

2. **Converted Policy:** If this policy is issued as the result of Your exercising a conversion privilege provided under any other health insurance policy issued by Us, the time periods specified in this Time Limit on Certain Defenses provision shall be deemed to have commenced on the Effective Date of Coverage for You under the policy from which the conversion occurred.

SECTION 10: MUTUAL CONDITIONS

1. Membership, While this policy is in force, You are entitled to vote at all meetings of members and to receive dividends the Board of Directors in its discretion may declare in accordance with reasonable classifications and groupings of policy holders established by such Board.

2. No Contingent Liability. This policy is non-assessable.

3. Annual Meeting. The annual meeting of the members of the company shall be held at its home office at Bloomington, Illinois, on the second Monday of June at the hour of 10:00 A.M., unless the Board of Directors shall elect to change the time and place of such meeting, in which case, but not otherwise, due notice shall be mailed to each member at the address disclosed in this policy at least 10 days prior thereto.

IN WITNESS WHEREOF, THE STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY has caused this policy to be signed by its President and Secretary at Bloomington, Illinois, and countersigned on page one by a duly licensed resident agent of the Company.

Kim M. Brunner

Secretary

Vincent J. Trosino

President

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY
Home Office: Bloomington, Illinois
Outline of Medicare Supplement Coverage – Cover Page

Benefit Plans "A", "C", and "F" Are Offered By State Farm Mutual Automobile Insurance Company

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. [Plans E, H, I and J are no longer available for sale.]

BASIC BENEFITS:

HOSPITALIZATION: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

MEDICAL EXPENSES: Part B coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L and N require insured to pay a portion of Part B coinsurance or co-payments.

BLOOD: First three pints of blood each year.

HOSPICE: Part A coinsurance

A	B	C	D	F/F *	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, Including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit [$4,620]; paid at 100% after limit reached	Out-of-pocket limit [$2,310]; paid at 100% after limit reached		

*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,000] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

STEP RATE PREMIUMS
Individual Male or Female

Medicare Supplement Plan A

Premium – All Ages			
Annual	Semiannual	Quarterly	SFPP
[$ 1,434.00]	[$ 731.34]	[$ 372.84]	[$ 121.89]

Medicare Supplement Plan C

Premium – All Ages			
Annual	Semiannual	Quarterly	SFPP
[$ 2,163.00]	[$ 1,103.13]	[$ 562.38]	[$ 183.85]

Medicare Supplement Plan F

Premium – All Ages			
Annual	Semiannual	Quarterly	SFPP
[$ 2,185.00]	[$ 1,114.35]	[$ 568.10]	[$ 185.72]

PREMIUM INFORMATION

We State Farm Mutual Automobile Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

[This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.]

READ YOUR POLICY VERY CAREFULLY

This is only an outline, describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to your State Farm agent or the Greeley Health Operations Center at P.O. Box 339404 Greeley, Colorado 80633-9404. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

Neither State Farm Mutual Automobile Insurance Company nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN "A"

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,068]	$0	[$1,068] (Part A deductible)
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0 **
-Beyond the additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	$0	Up to [$133.50] a day
101st day and after	$0	$0	All Costs
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN "A"

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 [$135] (Part B deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD First 3 pints Next [$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All Costs $0 20%	 $0 [$135] (Part B deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First [$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 [$135] (Part B deductible) $0

PLAN "C"

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% Medicare eligible expenses	$0 **
-Beyond the additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN "C"

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$135] of Medicare Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next [$135] of Medicare Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First [$135] of Medicare Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.			
First $250 of each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN "F"

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0 **
-Beyond the additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All Costs
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN "F"

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$135] of Medicare Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next [$135] of Medicare Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First [$135] of Medicare Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.			
First $250 of each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

HEALTH INSURANCE

State Farm Mutual Automobile Insurance Company
Home Office, Bloomington, IL 61710

Doc Type: **01**

Medicare Supplement Application

NEW	REINSTATEMENT APP	BENEFIT CHANGE (EXPLAIN)	POLICY NUMBER

Section One - Proposed Insured

LAST NAME			
FIRST NAME		MIDDLE INITIAL	
RESIDENCE ADDRESS			
RESIDENCE ADDRESS			
CITY		STATE	
ZIP CODE	COUNTY		
SEX	BIRTHDATE	AGE	MEDICARE ELIGIBILITY DATE
MEDICARE HEALTH INSURANCE NUMBER (MHIN)			

Section Two - Coverage

(See the Health Rate book for Plans offered in your state and complete below.)

Applying for Plan _____

Method of Payment

MODE (Check One)	SFPP	A	SA	Q	PREMIUM
					$
SFPP NUMBER					AMOUNT SUBMITTED
					$

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

Section Three

To the best of your knowledge,

	YES	NO
1. a. Did you turn age 65 in the last 6 months?	☐	☐
b. Have you enrolled in both Medicare Parts A and B? (**If no,** you are ineligible and an application should not be submitted.)	☐	☐
c. Did you enroll in Medicare Part B in the last 6 months?	☐	☐

d. If yes, what is the Medicare Part B effective date?

MONTH	DAY	YEAR

	YES	NO
2. a. Are you covered for medical assistance through the state Medicaid program? (**NOTE TO APPLICANT:** If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)	☐	☐
b. If yes, will Medicaid pay your premiums for this Medicare supplement policy?	☐	☐

c. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ ☐

YES NO

3. a. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? ☐ ☐

(**If no,** skip to question 4a.)
(**If yes,** answer 3b through 3f.)

b. Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START | MONTH DAY YEAR | END | MONTH DAY YEAR |

c. If you are still covered under this type of Medicare plan, do you intend to replace your current coverage with this State Farm® Medicare supplement policy? ☐ ☐

(**If yes,** complete the "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage".)

(**If no,** you are ineligible and an application should not be submitted.)

d. Was this your first time in this type of Medicare plan? ☐ ☐

e. Did you drop a Medicare supplement policy to enroll in this type of Medicare plan? ☐ ☐

f. If 3e is yes, was this a State Farm Medicare supplement policy? ☐ ☐

YES NO

4. a. Do you have another Medicare supplement policy or certificate in force? ☐ ☐

(**If yes,** complete details in the table on the next page.)

b. If question 4a is yes, do you intend to replace your current Medicare supplement policy or certificate with this policy? ☐ ☐

(**If yes,** complete the "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage".)

(**If no,** you are ineligible and an application should not be submitted.)

YES NO

5. a. Have you had coverage under any other health insurance within the past 63 days? ☐ ☐
(For example, an employer, union, individual, PACE plan, or demonstration plan)

(**If yes,** complete details in the table on the next page.)

b. If question 5a is yes, are you still covered under this other health insurance? ☐ ☐

c. If question 5b is yes, do you intend to replace the other health coverage with this Medicare supplement policy? ☐ ☐

COMPANY, PLAN, PROGRAM OR ORGANIZATION	BENEFITS PROVIDED		
CARRIER'S PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE	TERMINATION DATE
REASON FOR TERMINATION			

IF YOU HAVE MEDICARE SUPPLEMENT COVERAGE IN FORCE OR ARE ENROLLED IN A MEDICARE ADVANTAGE PLAN, YOU ARE INELIGIBLE UNLESS THE EXISTING COVERAGE IS TO BE REPLACED BY THIS POLICY.

Section Four

If you are within a mandated open enrollment or guaranteed issue period you do not need to answer questions 6a, 6b, or 6c.

YES NO

6. a. Are you now bedridden or confined to a hospital or nursing facility or planning such confinement and/or surgery? ☐ ☐

b. Within the past 12 months have you had or been told you had by a medical practitioner or been treated for heart disease or stroke; Parkinson's or Alzheimer's disease; dementia; cancer; AIDS (Acquired Immune Deficiency Syndrome); depression or anxiety; chronic liver, lung, or kidney disease; diabetes mellitus; or disabling arthritis? ☐ ☐

c. Have you had or been advised to have an organ transplant? ☐ ☐

(If the answer to question 6a, 6b, or 6c is yes, you are ineligible and an application should not be submitted.)

PLEASE BE SURE TO READ THE FOLLOWING INFORMATION

1. You do not need more than one Medicare supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Section Five - Signature Section

I represent that my answers and statements in this application are true and complete and agree that:

(a) failure to completely and correctly disclose my medical history may result in the coverage being voided from the effective date;

(b) no agent has authority to waive the answer to any question in the application, to pass on insurability, to waive any of the Company's rights or requirements or to make or alter any contract; and

(c) no insurance will be effective unless a policy is issued as applied for and delivered.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I certify that I have been provided with an Outline of Coverage and a Guide to Health Insurance for People with Medicare.

THE CONDITIONAL RECEIPT HAS BEEN EXPLAINED TO ME. I UNDERSTAND THAT I WILL NOT RECEIVE ANY INSURANCE COVERAGE FOR MY MONEY UNLESS A POLICY IS ISSUED AS APPLIED FOR AND DELIVERED.

All questions on the application have been asked and the information supplied has been truly and accurately recorded. The Conditional Receipt has been explained and given to the Proposed Insured or an authorized representative. **X** _____ **Signature of Agent**	Dated on _____ MONTH DAY YEAR at _____ CITY STATE **X** _____ **Signature of Proposed Insured**
Agent's Code Stamp	**FUTURE EFFECTIVE DATE** (if applicable) MONTH DAY YEAR
Mailing Address if different from Residence Address	

Agent's Remarks: (List other health insurance policies sold to the applicant in the past five years and indicate those which are currently in force.)

A **HEALTH INSURANCE**

State Farm Mutual Automobile Insurance Company
Home Office, Bloomington, IL 61710

BAR CODE ONLY

Doc Type: 36

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by State Farm Mutual Automobile Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT (BROKER OR OTHER REPRESENTATIVE): I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement, or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

- ☐ Other (please specify).

1. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting period, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

2. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

(Signature of Agent, Broker or Other Representative)

_____

(Printed Name and Address of Issuer, Agent or Broker)

_____ _____

(Applicant's Signature) (Date)

SERFF Tracking Number:	*STFH-126337913*	*State:*	*Arkansas*
Filing Company:	*State Farm Mutual Automobile Insurance Company*	*State Tracking Number:*	*43748*
Company Tracking Number:	*97037 HAR, 97038 HAR, 97039 HAR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.003 Plan C 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*2010 Med Supp/97037 HAR, 97038 HAR, 97039 HAR*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved 12/16/2009	AR Rates-Std 2010	97037 HAR, 97039 HAR, 97038 HAR	New		AR Rates - Std 2010.pdf
Approved 12/16/2009	AR Monthly Rates	97037 HAR, 97039 HAR, 97038 HAR	New		AR Rates - Std 2010-monthly.pdf

State Farm Mutual Automobile Insurance Company
Bloomington, Illinois

Medicare Supplement Policy Forms 97037 HAR, 97038 HAR, and 97039 HAR
Annual Premiums
Individual Male or Female

Proposed Rates (06/01/10 Effective Date)

Policies Issued on or after 6/1/2010

	Plan A Form 97037 HAR *ER_C1434*	Plan C Form 97038 HAR *ER_C2163*	Plan F Form 97039 HAR *ER_C2185*
All Ages	1,434.00	2,163.00	2,185.00

Semiannual Mode: 51% Annual
Quarterly Mode: 26% Annual

Arkansas

State Farm Mutual Automobile Insurance Company
Bloomington, Illinois

Medicare Supplement Policy Forms 97037 HAR, 97038 HAR, and 97039 HAR
Monthly Premiums
Individual Male or Female

Proposed Rates (06/01/10 Effective Date)

Policies Issued on or after 6/1/2010

	Plan A Form 97037 HAR *ER_C0122*	Plan C Form 97038 HAR *ER_C0184*	Plan F Form 97039 HAR *ER_C0186*
All Ages	121.89	183.85	185.72

Arkansas

SERFF Tracking Number:	*STFH-126337913*	*State:*	*Arkansas*
Filing Company:	*State Farm Mutual Automobile Insurance Company*	*State Tracking Number:*	*43748*
Company Tracking Number:	*97037 HAR, 97038 HAR, 97039 HAR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.003 Plan C 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*2010 Med Supp/97037 HAR, 97038 HAR, 97039 HAR*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	12/16/2009

Comments:

Attachment:

Readability Score and Certification.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Accepted for Informational Purposes	12/16/2009

Comments:

Attachment:

1002336 AR.pdf

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Accepted for Informational Purposes	12/16/2009

Comments:

Attachment:

AR- Med. Supp. Outline of Coverage-1002209 (with [ ]'s).pdf

		Item Status:	Status Date:
Satisfied - Item:	Annual Notice Letter	Accepted for Informational Purposes	12/16/2009

Comments:

Attachment:

Annual Notice Letter.pdf

SERFF Tracking Number:	*STFH-126337913*	*State:*	*Arkansas*
Filing Company:	*State Farm Mutual Automobile Insurance Company*	*State Tracking Number:*	*43748*
Company Tracking Number:	*97037 HAR, 97038 HAR, 97039 HAR*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.003 Plan C 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*2010 Med Supp/97037 HAR, 97038 HAR, 97039 HAR*		

		Item Status:	**Status Date:**
Satisfied - Item:	Cover Letter	Accepted for Informational Purposes	12/16/2009

Comments:

Attachment:

AR Cover Letter.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	Important Notice Sticker	Accepted for Informational Purposes	12/16/2009

Comments:

Attachment:

Important Notice Sticker 001.pdf

READABILITY SCORE AND CERTIFICATION

The Flesch reading ease test score for the following forms are:

2010 Medicare Supplement Policy-Plan A – 97037 HAR – 52.2
2010 Medicare Supplement Policy-Plan C – 97038 HAR – 50.2
2010 Medicare Supplement Policy-Plan F – 97039 HAR – 50.9
Medicare Supplement Application – 1002336 – 60.4

This meets the minimum reading ease test score required in this state.

_____

Mary F. Keim
Assistant Secretary/Treasurer

HEALTH INSURANCE

State Farm Mutual Automobile Insurance Company
Home Office, Bloomington, IL 61710

Doc Type: **01**

Medicare Supplement Application

NEW	REINSTATEMENT APP	BENEFIT CHANGE (EXPLAIN)	POLICY NUMBER

Section One - Proposed Insured

LAST NAME			
FIRST NAME		MIDDLE INITIAL	
RESIDENCE ADDRESS			
RESIDENCE ADDRESS			
CITY		STATE	
ZIP CODE	COUNTY		
SEX	BIRTHDATE	AGE	MEDICARE ELIGIBILITY DATE
MEDICARE HEALTH INSURANCE NUMBER (MHIN)			

Section Two - Coverage

(See the Health Rate book for Plans offered in your state and complete below.)

Applying for Plan _____

Method of Payment

MODE (Check One)	SFPP	A	SA	Q	PREMIUM
					$
SFPP NUMBER					AMOUNT SUBMITTED
					$

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

Section Three

To the best of your knowledge,

	YES	NO
1. a. Did you turn age 65 in the last 6 months?	☐	☐
b. Have you enrolled in both Medicare Parts A and B? (**If no,** you are ineligible and an application should not be submitted.)	☐	☐
c. Did you enroll in Medicare Part B in the last 6 months?	☐	☐

d. If yes, what is the Medicare Part B effective date?

MONTH	DAY	YEAR

	YES	NO
2. a. Are you covered for medical assistance through the state Medicaid program? (**NOTE TO APPLICANT:** If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)	☐	☐
b. If yes, will Medicaid pay your premiums for this Medicare supplement policy?	☐	☐

c. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ ☐

YES NO

3. a. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? ☐ ☐

(**If no,** skip to question 4a.)
(**If yes,** answer 3b through 3f.)

b. Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START | MONTH DAY YEAR | END | MONTH DAY YEAR |

c. If you are still covered under this type of Medicare plan, do you intend to replace your current coverage with this State Farm® Medicare supplement policy? ☐ ☐

(**If yes,** complete the "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage".)

(**If no,** you are ineligible and an application should not be submitted.)

d. Was this your first time in this type of Medicare plan? ☐ ☐

e. Did you drop a Medicare supplement policy to enroll in this type of Medicare plan? ☐ ☐

f. If 3e is yes, was this a State Farm Medicare supplement policy? ☐ ☐

YES NO

4. a. Do you have another Medicare supplement policy or certificate in force? ☐ ☐

(**If yes,** complete details in the table on the next page.)

b. If question 4a is yes, do you intend to replace your current Medicare supplement policy or certificate with this policy? ☐ ☐

(**If yes,** complete the "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage".)

(**If no,** you are ineligible and an application should not be submitted.)

YES NO

5. a. Have you had coverage under any other health insurance within the past 63 days? ☐ ☐
(For example, an employer, union, individual, PACE plan, or demonstration plan)

(**If yes,** complete details in the table on the next page.)

b. If question 5a is yes, are you still covered under this other health insurance? ☐ ☐

c. If question 5b is yes, do you intend to replace the other health coverage with this Medicare supplement policy? ☐ ☐

COMPANY, PLAN, PROGRAM OR ORGANIZATION	BENEFITS PROVIDED		
CARRIER'S PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE	TERMINATION DATE
REASON FOR TERMINATION			

IF YOU HAVE MEDICARE SUPPLEMENT COVERAGE IN FORCE OR ARE ENROLLED IN A MEDICARE ADVANTAGE PLAN, YOU ARE INELIGIBLE UNLESS THE EXISTING COVERAGE IS TO BE REPLACED BY THIS POLICY.

Section Four

If you are within a mandated open enrollment or guaranteed issue period you do not need to answer questions 6a, 6b, or 6c.

YES NO

6. a. Are you now bedridden or confined to a hospital or nursing facility or planning such confinement and/or surgery? ☐ ☐

b. Within the past 12 months have you had or been told you had by a medical practitioner or been treated for heart disease or stroke; Parkinson's or Alzheimer's disease; dementia; cancer; AIDS (Acquired Immune Deficiency Syndrome); depression or anxiety; chronic liver, lung, or kidney disease; diabetes mellitus; or disabling arthritis? ☐ ☐

c. Have you had or been advised to have an organ transplant? ☐ ☐

(If the answer to question 6a, 6b, or 6c is yes, you are ineligible and an application should not be submitted.)

PLEASE BE SURE TO READ THE FOLLOWING INFORMATION

1. You do not need more than one Medicare supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Section Five - Signature Section

I represent that my answers and statements in this application are true and complete and agree that:

(a) failure to completely and correctly disclose my medical history may result in the coverage being voided from the effective date;

(b) no agent has authority to waive the answer to any question in the application, to pass on insurability, to waive any of the Company's rights or requirements or to make or alter any contract; and

(c) no insurance will be effective unless a policy is issued as applied for and delivered.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I certify that I have been provided with an Outline of Coverage and a Guide to Health Insurance for People with Medicare.

THE CONDITIONAL RECEIPT HAS BEEN EXPLAINED TO ME. I UNDERSTAND THAT I WILL NOT RECEIVE ANY INSURANCE COVERAGE FOR MY MONEY UNLESS A POLICY IS ISSUED AS APPLIED FOR AND DELIVERED.

All questions on the application have been asked and the information supplied has been truly and accurately recorded. The Conditional Receipt has been explained and given to the Proposed Insured or an authorized representative. **X** _____ **Signature of Agent**	Dated on _____ MONTH DAY YEAR at _____ CITY STATE **X** _____ **Signature of Proposed Insured**
Agent's Code Stamp	**FUTURE EFFECTIVE DATE** (if applicable) MONTH DAY YEAR
Mailing Address if different from Residence Address	

Agent's Remarks: (List other health insurance policies sold to the applicant in the past five years and indicate those which are currently in force.)

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY
Home Office: Bloomington, Illinois
Outline of Medicare Supplement Coverage – Cover Page

Benefit Plans "A", "C", and "F" Are Offered By State Farm Mutual Automobile Insurance Company

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. [Plans E, H, I and J are no longer available for sale.]

BASIC BENEFITS:

HOSPITALIZATION: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

MEDICAL EXPENSES: Part B coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L and N require insured to pay a portion of Part B coinsurance or co-payments.

BLOOD: First three pints of blood each year.

HOSPICE: Part A coinsurance

A	B	C	D	F/F *	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, Including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit [$4,620]; paid at 100% after limit reached	Out-of-pocket limit [$2,310]; paid at 100% after limit reached		

*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,000] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

STEP RATE PREMIUMS
Individual Male or Female

Medicare Supplement Plan A

Premium – All Ages			
Annual	Semiannual	Quarterly	SFPP
[$ 1,434.00]	[$ 731.34]	[$ 372.84]	[$ 121.89]

Medicare Supplement Plan C

Premium – All Ages			
Annual	Semiannual	Quarterly	SFPP
[$ 2,163.00]	[$ 1,103.13]	[$ 562.38]	[$ 183.85]

Medicare Supplement Plan F

Premium – All Ages			
Annual	Semiannual	Quarterly	SFPP
[$ 2,185.00]	[$ 1,114.35]	[$ 568.10]	[$ 185.72]

PREMIUM INFORMATION

We State Farm Mutual Automobile Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

[This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.]

READ YOUR POLICY VERY CAREFULLY

This is only an outline, describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to your State Farm agent or the Greeley Health Operations Center at P.O. Box 339404 Greeley, Colorado 80633-9404. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

Neither State Farm Mutual Automobile Insurance Company nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN "A"

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,068]	$0	[$1,068] (Part A deductible)
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0 **
-Beyond the additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	$0	Up to [$133.50] a day
101st day and after	$0	$0	All Costs
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN "A"

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First [$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 [$135] (Part B deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD First 3 pints Next [$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All Costs $0 20%	 $0 [$135] (Part B deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care services and medical supplies -Durable medical equipment First [$135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 [$135] (Part B deductible) $0

PLAN "C"

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% Medicare eligible expenses	$0 **
-Beyond the additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN "C"

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$135] of Medicare Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next [$135] of Medicare Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First [$135] of Medicare Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.			
First $250 of each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN "F"

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,068]	[$1,068] (Part A deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but [$534] a day	[$534] a day	$0
-Once lifetime reserve days are used:			
-Additional 365 days	$0	100% of Medicare eligible expenses	$0 **
-Beyond the additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All Costs
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN "F"

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$135] of Medicare Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next [$135] of Medicare Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment			
First [$135] of Medicare Approved Amounts*	$0	[$135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.			
First $250 of each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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POLICY NUMBER
H GXXXXXXXXXXXXXXX

Medicare Supplement
MXXXXXXXX

IXX XX, XXXX

Dear AXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

The purpose of this notice is to inform you of changes the Department of Health and Human Services has made to the Medicare Part A deductible and co-payment amounts for [2010].

	[2009]	**[2010]**
Part A Deductible (First 60 days of hospital confinement)	[$1,068.00]	[$X,XXX.XX]
Co-payment Amount for each day of hospital confinement (61st - 90th day)	[$267.00]	[$XXX.XX]
Co-payment Amount for each Lifetime Reserve day used (91st to 150th day)	[$534.00]	[$XXX.XX]
Co-payment Amount for Skilled Nursing Facility Care (21st to 100th day)	[$133.50]	[$XXX.XX]

[The Medicare Part B deductible amount for [2010] will remain $XXX.XX. The Medicare Part B premium will remain $XX.XX.]

Your policy's benefits (if applicable) will be increased to correspond with the changes shown above. You will be advised of any premium adjustment due to these changes, if necessary, with your renewal billing notice.

Policyholder Information Service
Health Insurance Division
State Farm Mutual Automobile Insurance Company

U19

State Farm Mutual Automobile Insurance Company
Home Office, Bloomington, Illinois 61710

October 9, 2009

Jay Bradford, Commissioner
Arkansas Insurance Department
1200 W 3rd Street
Little Rock, AR 72201-1904

Re: NAIC # 176-25178
Individual Accident & Health
2010 Medicare Supplement Policy – Plan A Form 97037 HAR
2010 Medicare Supplement Policy – Plan C Form 97038 HAR
2010 Medicare Supplement Policy – Plan F Form 97039 HAR
Medicare Supplement Outline of Coverage 1002209
Medicare Supplement Application Form 1002336
Medicare Supplement Replacement Notice 125593.1
Medicare Supplement Rates

Dear Commissioner:

Enclosed for filing on behalf of the State Farm Mutual Automobile Insurance Company of Bloomington, Illinois are the referenced forms. These forms are to be used to satisfy the Benefit Standards for the 2010 Standardized Medicare Supplement Benefit Plans effective June 1, 2010.

2010 Medicare Supplement Policy – Plan A Form 97037 HAR
2010 Medicare Supplement Policy – Plan C Form 97038 HAR
2010 Medicare Supplement Policy – Plan F Form 97039 HAR

2010 Medicare Supplement Policy – Plan A Form 97037 HAR will replace Medicare Supplement Policy – Plan A Form 97037 AR, approved October 9, 1996.

2010 Medicare Supplement Policy – Plan C Form 97038 HAR will replace Medicare Supplement Policy – Plan C Form 97038 AR, approved October 9, 1996.

2010 Medicare Supplement Policy – Plan F Form 97039 HAR will replace Medicare Supplement Policy – Plan F form 97039 AR, approved October 9, 1996.

The 2010 Medicare Supplement Policies have been created to satisfy the Medicare Supplement Requirements for 2010 based on Arkansas Rule 27, Section 9.1.

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Medicare Supplement Outline of Coverage 1002209

Medicare Supplement Outline of Coverage 1002210 includes the 2009 Medicare Deductible Amounts but will be modified once the 2010 Medicare Deductible Amounts have been determined. We have bracketed both the rates and deductible amounts to reflect the variability that may occur from year to year.

Please note that we have also bracketed the following areas so that required language can be removed as of June 1, 2011:

1. The last sentence in paragraph 1 of the cover page.
2. The second paragraph in the Disclosures section.

A readability certificate has not been completed since the outline being submitted is in the format required by Arkansas Rule 27, Section 17 (D).

Medicare Supplement Application 1002336

Medicare Supplement Application 1002336 will replace Medicare Supplement Application 128425, approved November 28, 2005. The following changes have been made:

1. The application has been reformatted which has resulted in numbering changes throughout the application.
2. Revised wording at the beginning of section 4.
3. Added dementia to question 6b.
4. Added new questions 1a and 6c.
5. Other minor editorial or verbiage changes.

Medicare Supplement Replacement Form 125593.1

Medicare Supplement Replacement Form 125593.1 will replace Medicare Supplement Replacement Form 125593 approved November 28, 2005. Minor editorial and verbiage changes have been made to the document.

State Farm Mutual Automobile Insurance Company
Bloomington, Illinois 61710-0001

Jay Bradford
Page 3
October 9, 2009

Medicare Supplement Rates

Attached are the Medicare Supplement rates and actuarial memorandum for utilization with the 97037 HAR, 97038 HAR and 97039 HAR policies. These same rates were approved September 4, 2007 for use with the 97037 AR, 97038 AR and 97039 AR policies.

We will use the following previously approved forms with these policies:

Form #	Name of Form	Approval Date
99005	Amendment of Application	06-29-70
99586.1-PW	Important Notice Sticker	10-9-96

If you have any questions, please let us know.

Sincerely,

Barb Metz

Barb Metz
Analyst – Health Contracts & Compliance
(309) 766-6544
FAX (309) 766-8483
Email – Barb.Metz.bfn5@statefarm.com

p.s. We are submitting a copy of the letter (form #121707.6) sent annually to advise insured's of the Medicare Deductible/Premium changes. This filing is for informational purposes only.

99586.1-PW

Important Notice

Please read the copy of the application attached to this policy. Carefully check the application and write to State Farm Insurance Companies, Greeley Health Operations Center, P. O. Box 339404, Greeley, Colorado 80633-9404, within ten days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is a part of the policy and the policy was issued on the basis that answers to all questions and the information shown on the application are correct and complete.

99586.1-PW Printed in U.S.A. Rev. 01-26-2006

Important Sticker – Bold
Background of Sticker - Yellow
Print on Sticker – Red